APPENDIX E

PREADMISSION/CONTINUED STAY INPATIENT CARE TRANSMITTAL

(FORM 10A)

and INSTRUCTIONS

[redacted]

☐ ATTACHMENT INDICATOR

PREADMISSION/CONTINUED STAY

Inpatient Care Transmittal

Document No
0000000

FORM NUMBER
24-06-49

UTAH DEPARTMENT OF HEALTH
MEDICAL SERVICES FORM

1. Client Last Name	2. Client First Name	3. Date of Birth MM / DD / YY	4. Sex	5. Client ID Number

6. Client: Street City State Zip Code | 7. Client Social Security No

8. Does Client have health Insurance other than Medicaid? ☐ Yes ☐ No (A) (B)	9. If yes, give health insurance policy number	10. If client has health insurance, give insurance company Name, Address, Zip Code

11. Medicare Covered Period From To	12. Medicare ID No	13. Admission Date into Facility MM DD YY	14. TPL ☐ TPL Amount _____

15. Attending Physician Name | 16. Attending Physician License Number

17. Admitting Physician Name | 18. Admitting Physician License No

19. Responsible Party and/or Next of Kin | 20. Relationship | 21 Telephone

22. Street Address | 23. City | 24. State/Zip Code

	25. ICD -9-CM Code	26. Diagnosis Description	27. Onset MM/YY
1			/
2			/
3			/
4			/
5			/
6			/
7			/

	ICD-9-CM Code	Diagnosis Description	Onset MM/YY
8			/
9			/
10			/

	28. ICD -9-CM Code	29. Surgical Procedure Description	30. Date MM/YY
1			/
2			/
3			/

31. Provider: Name, Address, Zip Code Phone No. | 32. Medicaid Provider No.

34. The PROVIDER recommends that the care/services required by this patient to be (check one):

☐ ICF/MR-I ☐ Nursing Facility I ☐ Intensive Skilled Care
☐ ICF/MR-II ☐ Nursing Facility II ☐ Undetermined
☐ ICR/MR-III ☐ Nursing Facility III ☐ Other _____

35._____
Signature of Administrator or Administrative Designee Date

33._____
Signature of Director of Nursing or Designated Charge Nurse Date
(Nursing Facility Only)

36._____
Signature of QMRP (ICF/MR Facility Only) Date

37. Approved ☐

STATE USE ONLY

38. Begin Date _____/ _____/ _____ MM DD YY
End Date _____/ _____/ _____ MM DD YY

40. Level of Care:
☐ NF I ☐ NF II ☐ NF III
☐ Intensive Skilled Care ☐ ICF/MR I ☐ ICF/MR II ☐ ICF/MR-III

41. Denial Code

42. Reviewer I.D.

39. A. Primary Diagnosis

B. Secondary Diagnosis | | | | | | |

43a._____
_____
Signature Date M M D D Y Y

b.
_____
_
Signature Date M M D D Y Y

Remarks: